FOR OHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035642

Facility Name: NEW BEGINNINGS CARE CENTRE

Address: 1000 DIXON AVENUE (Number) ROCK FALLS (City) 61071 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 625-8510 **Fax #** (815) 625-8443

IDPA ID Number: 36-3651790

Date of Initial License for Current Owners: 07/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROBERT HEDGES
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,075	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,111	2,111	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	12,140	900		13,040	12
13	DD 16 OR LESS					13
14	TOTALS	12,140	900	2,111	15,151	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.47%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 55 and days of care provided 2,111

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	112,685	4,172	4,094	120,951		120,951		120,951			1
2	Food Purchase		60,060		60,060	(3,194)	56,866	(6)	56,860			2
3	Housekeeping	47,347	6,092		53,439		53,439		53,439			3
4	Laundry	25,416	4,134	1,153	30,703		30,703		30,703			4
5	Heat and Other Utilities			60,059	60,059		60,059	470	60,529			5
6	Maintenance	23,048	4,573	16,654	44,275		44,275	2,634	46,909			6
7	Other (specify):*			5,179	5,179		5,179		5,179			7
8	**TOTAL General Services**	208,496	79,031	87,139	374,666	(3,194)	371,472	3,098	374,570			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	648,752	103,220	11,947	763,919	(171,759)	592,160		592,160			10
10a	Therapy			95,811	95,811		95,811		95,811			10a
11	Activities	38,927	513		39,440		39,440		39,440			11
12	Social Services	22,622		2,499	25,121		25,121		25,121			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	710,301	103,733	114,457	928,491	(171,759)	756,732		756,732			16
	C. General Administration											
17	Administrative	55,111		13,000	68,111		68,111	27,384	95,495			17
18	Directors Fees											18
19	Professional Services			45,108	45,108		45,108	(6,829)	38,279			19
20	Dues, Fees, Subscriptions & Promotions			9,854	9,854		9,854	(3,673)	6,181			20
21	Clerical & General Office Expenses	32,119	4,466	14,171	50,756		50,756	2,189	52,945			21
22	Employee Benefits & Payroll Taxes			196,656	196,656	3,194	199,850		199,850			22
23	Inservice Training & Education											23
24	Travel and Seminar			194	194		194	1,184	1,378			24
25	Other Admin. Staff Transportation			3,198	3,198		3,198		3,198			25
26	Insurance-Prop.Liab.Malpractice			42,563	42,563		42,563	1,080	43,643			26
27	Other (specify):*			20,210	20,210		20,210	(11,024)	9,186			27
28	**TOTAL General Administration**	87,230	4,466	344,954	436,650	3,194	439,844	10,311	450,155			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,006,027	187,230	546,550	1,739,807	(171,759)	1,568,048	13,409	1,581,457			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: NEW BEGINNINGS CARE CENTRE #0035642 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,094	
	REPAIRS & MAINTENANCE		0	
			0	4,094
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,153	
			0	1,153
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		22,815	
	ELECTRICITY		17,617	
	WATER		15,624	
	CABLE TV - LOBBY		4,003	
			0	60,059
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,812	
	PAINTING & DECORATING		1,943	
	BUILDING REPAIRS		4,247	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,926	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		868	
	FIRE SERVICE		2,858	
			0	
			0	
			0	16,654
7	**OTHER**			
	SCAVENGER		5,179	
	SECURITY SERVICE		0	5,179
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,200	4,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		11,347	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	600	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	11,947
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		75,208	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		18,065	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,538	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	95,811
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		649	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,850	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	2,499
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE **#0035642** **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	13,000	13,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	14,800	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	30,308	
			0	45,108
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,282	
	EMPLOYEE WANT ADS	XIX F	1,877	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	323	
	LICENSES & PERMITS	XIX F	2,431	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,789	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,152	9,854
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		2,695	
	EQUIPMENT REPAIR & MAINTENANCE		900	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,500	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		7,076	
	MESSENGER SERVICE		0	
			0	14,171

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	77,268	
	UNEMPLOYMENT COMPENSATION	XIX D	52,470	
	WORKERS COMPENSATION INSURANCI	XIX D	47,650	
	HOSPITALIZATION INSURANCE	XIX D	11,894	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,374	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	196,656
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	194	
	TRAVEL	XIX G	0	
			0	
			0	194
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,198	3,198
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		42,563	42,563
27	**OTHER**			
	BAD DEBTS	VI 24	20,210	
				20,210

GRAND TOTAL COLUMN 3 OTHER 546,550

NEW BEGINNINGS CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	60,060	PATIENT MEALS	45453
LESS SALES TAX	(6)	ADD EMPLOYEE MEALS	2555
NET FOOD	60,054	TOTAL MEALS/YEAR	48008
TOTAL PATIENT CENSUS	15,151	NET FOOD	60054
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	48008
TOTAL PATIENT MEALS	45453	COST PER MEAL	1.25
		TIME EMPLOYEE MEALS	2555
ADD # EMPLOYEE MEALS/DAY	7		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	3194
TOTAL EMPLOYEE MEALS	2555		

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE #0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			10,793	10,793		10,793	30,989	41,782			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,793	31,793		31,793	75,153	106,946			32
33	Real Estate Taxes			16,131	16,131		16,131		16,131			33
34	Rent-Facility & Grounds			133,169	133,169		133,169	(133,169)				34
35	Rent-Equipment & Vehicles			7,546	7,546		7,546		7,546			35
36	Other (specify):*											36
37	**TOTAL Ownership**			199,432	199,432		199,432	(27,027)	172,405			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					171,759	171,759		171,759			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,447	30,447		30,447		30,447			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			30,447	30,447	171,759	202,206		202,206			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,006,027	187,230	776,429	1,969,686		1,969,686	(13,618)	1,956,068			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,885	30		9
10	Interest and Other Investment Income	(3,235)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,500)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,210)	27		24
25	Fund Raising, Advertising and Promotional	(2,282)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,789)	20		28
29	Other-Attach Schedule	(14,999)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (41,136)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	27,518		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 27,518		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (13,618)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

NEW BEGINNINGS CARE CENTRE

ID# 0035642

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (988)	6	1
2	MARKETING SALARY	(4,072)	21	2
3	BANK CHARGES	(2,695)	21	3
4	DUANE & MORRIS	(744)	19	4
5				5
6	DATA PROCESSING - HEALTH CARE HORIZ	(6,500)	19	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,999)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6)	0	0	0	0	0	0	0	0	0	0	(6)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	470	0	0	0	0	0	0	0	0	0	470	5
6	Maintenance	(988)	3,622	0	0	0	0	0	0	0	0	0	2,634	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(994)	4,092	0	0	0	0	0	0	0	0	0	3,098	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	27,384	0	0	0	0	0	0	0	0	0	27,384	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,244)	415	0	0	0	0	0	0	0	0	0	(6,829)	19
20	Fees, Subscriptions & Promotions	(4,071)	398	0	0	0	0	0	0	0	0	0	(3,673)	20
21	Clerical & General Office Expenses	(10,267)	12,456	0	0	0	0	0	0	0	0	0	2,189	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,184	0	0	0	0	0	0	0	0	0	1,184	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,080	0	0	0	0	0	0	0	0	0	1,080	26
27	Other (specify):*	(20,210)	9,186	0	0	0	0	0	0	0	0	0	(11,024)	27
28	**TOTAL General Administration**	(41,792)	52,103	0	0	0	0	0	0	0	0	0	10,311	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,786)	56,195	0	0	0	0	0	0	0	0	0	13,409	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,885	0	25,654	450	0	0	0	0	0	0	0	30,989	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,235)	0	77,609	779	0	0	0	0	0	0	0	75,153	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(133,169)	0	0	0	0	0	0	0	0	(133,169)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,650	0	(29,906)	1,229	0	0	0	0	0	0	0	(27,027)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(41,136)	56,195	(29,906)	1,229	0	0	0	0	0	0	0	(13,618)	45

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WILLIAM IRVINE	50					
				HI CARE		
ROBERT HEDGES	50	SEE ATTACHED SCHEDULE		MANAGEMENT	SPRINGFIELD	MANAGEMENT
				H.I. PROPERTIES	SPRINGFIELD	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 13,000	HI CARE MANAGEMENT		$	$ (13,000)	1
2	V	5	UTILITIES				470	470	2
3	V	6	MAINTENANCE				3,622	3,622	3
4	V	17	OFFICER SALARIES				29,554	29,554	4
5	V	17	DIRECTOR OF OPERATIONS				4,074	4,074	5
6	V	17	DIERECTOR OF FINANCE				6,756	6,756	6
7	V	19	PROFESSIONAL FEES				415	415	7
8	V	20	DUES & SUBSRIPTIONS				398	398	8
9	V	21	OFFICE EXPENSE				12,456	12,456	9
10	V	24	TRAVE & SEMINARS				1,184	1,184	10
11	V	26	INSURANCE				1,080	1,080	11
12	V	27	PAYROLL TAXES/GROUP INS				9,186	9,186	12
13	V								13
14	Total			$ 13,000			$ 69,195	$ * 56,195	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 133,169	H & I PROPERTIES		$	$ (133,169)	15
16	V	30	DEPRECIATION				25,654	25,654	16
17	V	32	INTEREST				77,609	77,609	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 133,169			$ 103,263	$ * (29,906)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H & I PROPERTIES		$ 450	$ 450	15
16	V	32	INTEREST		H & I PROPERTIES		779	779	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 1,229	$ * 1,229	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.	50.00					$ 14,777	17-8	1
2	TOTAL SALARY RECEIVED FROM HI CARE $170,000										2
3											3
4											4
5											5
6	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00					14,777	17-8	6
7	TOTAL SALARY RECEIVED FROM HI CARE $170,000										7
8											8
9											9
10											10
11	MARTHA IRVINE	BOOKKEEPING							580	21-8	11
12	TOTAL SALARY RECEIVED FROM HI CARE $6672										12
13								TOTAL	$ 30,134		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HI CARE MANAGEMENT
Street Address: 1625 SOUTH 6TH STREET
City / State / Zip Code: SPRINGFIELD, IL. 62703
Phone Number: (217)528-0044
Fax Number: (217)528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	174,304	7	$ 5,408	$	15,151	$ 470	1
2	6	MAINTENANCE	PER RESIDENT DAY	174,304	7	41,669	34,507	15,151	3,622	2
3	17	OFFICER SALARY	PER RESIDENT DAY	174,304	7	340,000	340,000	15,151	29,554	3
4	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	174,304	7	46,873	46,873	15,151	4,074	4
5	17	DIRECTOR OF FINANCE	PER RESIDENT DAY	174,304	7	77,723	77,723	15,151	6,756	5
6	19	PROFESSIONAL FEES	PER RESIDENT DAY	174,304	7	4,774		15,151	415	6
7	20	DUES & SUBSRIPTION	PER RESIDENT DAY	174,304	7	4,580		15,151	398	7
8	21	OFFICE EXPENSE	PER RESIDENT DAY	174,304	7	143,304	89,662	15,151	12,456	8
9	24	TRAVEL & SEMINARS	PER RESIDENT DAY	174,304	7	13,622		15,151	1,184	9
10	26	INSURANCE	PER RESIDENT DAY	174,304	7	12,425		15,151	1,080	10
11	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	174,304	7	105,677		15,151	9,186	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 796,055	$ 588,765		$ 69,195	25

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: H & I PROPERTIES-NSG FACILITY
Street Address: 1625 S SIXTH STREET
City / State / Zip Code: SPRINGFIELD IL 62703
Phone Number: (217)528-0044
Fax Number: (217)528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 25,654	$	1	$ 25,654	1
2	32	INTEREST	DIRECT	1	1	77,609		1	77,609	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 103,263	$		$ 103,263	25

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: H & I PROPERTIES-OFFICE BUILDING
Street Address: 1625 S SIXTH STREET
City / State / Zip Code: SPRINGFIELD IL 62703
Phone Number: (217)528-0044
Fax Number: (217)528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	PER LICENSE BED	639	7	$ 5,226	$	55	$ 450	1
2	32	INTEREST	PER LICENSE BED	639	7	9,051		55	779	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 14,277	$		$ 1,229	25

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	ILLINI BANK		X	POWER LIFTER SCALE	$140.00	09/01/02	$ 4,291	$ 911	07/01/06	0.2248	$ 370	1
2	ILLINI BANK		X	DEBT CONSOLIDATION	$495.17	5/10/02	23,776	7,873	5/10/7	0.0914	970	2
3	related party office-us bank		X	MORTGAGE	$2,066.64	6/29/05	290,000	279,382	6/29/12	0.0635	779	3
4	related party-illini bank		X	MORTGAGE	$9,238.00	6/11/02	1,160,130		5/30/05	0.0725	52,944	4
5	related party-cole taylor		X	MORTGAGE	$10,935.59	08/03/05	1,410,500	1,405,342	08/01/10	0.0700	24,665	5
	Working Capital											
6	ILLINI BANK		X	LINE OF CREDIT	INTEREST	REVOLV		332,234	REVOLV	PRIME +	30,158	6
7	NB CHASE		X	AUTO LOAN	$648.17	2/28/02	27,044				295	7
8												8
9	TOTAL Facility Related				$23,523.57		$ 2,915,741	$ 2,025,742			$ 110,181	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,915,741	$ 2,025,742			$ 110,181	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE **#** 0035642 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	14,924	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	15,527	2
3. Under or (over) accrual (line 2 minus line 1).	$	603	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	15,528	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	16,131	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	14,206	8
2001	14,671	9
2002	14,834	10
2003	14,924	11
2004	15,527	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NEW BEGINNINGS CARE CENTRE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035642

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-27-401-002	NURSING HOME	$ 15,527.00	$ 15,527.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 15,527.00	$ 15,527.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	67,000	1998	$ 83,295	1
2					2
3	TOTALS	67,000		$ 83,295	3

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	55		1998		$ 698,118	$ 17,900	39	$ 17,900	$	$ 114,132	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT IMPROVEMENTS			1992	17,677	561	31.5	561		7,568	9
10	CURTAIN TRACKS			1993	5,650	179	31.5	179		2,320	10
11	REWIRING WORK			1996	6,043	155	39	155		1,492	11
12	ROOF			1997	66,564	1,707	39	1,707		14,154	12
13	OUTDOOR FLOODLIGHTS			1997	2,856	73	39	73		587	13
14	HANDRAILS& WALL GUARDS			1999	2,524	65	39	65		425	14
15	STORAGE BARN			1999	2,100	54	39	54		353	15
16	BACKFLOW PREVENTER			2000	1,696	62	27.5	62		343	16
17	ROOF			2000	2,680	97	27.5	97		538	17
18	NEW WATER HEATER			2001	3,096	113	27.5	113		513	18
19	ALARM SYSTEM			2001	5,013	182	27.5	182		827	19
20	OVERBED LIGHT			2001	3,687	134	27.5	134		609	20
21	CARPET			2001	1,730	199	5	346	147	1,730	21
22	WATER HEATER TANK			2002	1,678	61	27.5	61		216	22
23	ALARM SYSTEM			2002	4,991	182	27.5	182		645	23
24	WATER HEATER			2003	2,846	103	27.5	103		262	24
25	WATER HEATER			2004	5,299	193	27.5	193		346	25
26	WINDOWS			2005	35,827	163	27.5	163		163	26
27	SMOKE DETECTORS			2005	1,754	35	27.5	35		35	27
28	STEEL FIRE DOOR			2005	1,974	39	27.5	39		39	28
29	FIRE SYSTEM			2005	1,769	34	27.5	34		34	29
30											30
31											31
32											32
33											33
34											34
35											35
36	H & I PROPERTIES-OFFICE BUILDING			2005	22,626	450	39	450		450	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 898,198	$ 22,741		$ 22,888	$ 147	$ 147,781	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 60,211	$ 4,320	$ 5,795	$ 1,475	10	$ 35,587	71
72	Current Year Purchases	16,783	839	839		10	839	72
73	Fully Depreciated Assets	20,523				10	20,523	73
74	RELATED PARTY-SL	77,542	7,754	7,754			58,155	74
75	TOTALS	$ 175,059	$ 12,913	$ 14,388	$ 1,475		$ 115,104	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		95 BUICK CENTRY	2000	$ 6,181	$ 356	$	$ (356)	3	$ 6,181	76
77		2000 CADILLAC DEVILLE	2002	27,044	887	4,506	3,619	3	27,044	77
78										78
79										79
80	TOTALS			$ 33,225	$ 1,243	$ 4,506	$ 3,263		$ 33,225	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,189,777	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 36,897	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 41,782	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,885	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 296,110	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 133,169			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 133,169 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,546 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$ 0	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39.3	hrs	$		$ 24,029	$		$ 24,029	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39.3	hrs			82,839			82,839	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.3	# of prescrpts				64,891		64,891	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 106,868	$ 64,891		$ 171,759	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 54,701	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (25,000))	282,330		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,151		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	48,844		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 427,026	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	175,724		15
16	Equipment, at Historical Cost	112,003		16
17	Accumulated Depreciation (book methods)	(124,156)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 163,571	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 590,597	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 335,595	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	347,889		29
30	Accrued Salaries Payable	35,491		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,658		31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,528		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 758,161	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	776,327		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 776,327	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,534,488	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (943,891)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 590,597	$	48

*(See instructions.)

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (883,103)	1
2	Restatements (describe):		2
3	ROUNDING	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (883,106)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(60,785)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (60,785)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (943,891)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,850,664	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,850,664	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	55,002	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 55,002	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,235	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,235	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,908,901	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	374,666	31
32	Health Care	928,491	32
33	General Administration	436,650	33
	B. Capital Expense		
34	Ownership	199,432	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	30,447	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,969,686	40
41	**Income before Income Taxes (line 30 minus line 40)****	(60,785)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (60,785)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,819	2,083	$ 49,411	$ 23.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,358	3,628	81,462	22.45	3
4	Licensed Practical Nurses	8,418	9,213	158,153	17.17	4
5	CNAs & Orderlies	33,074	36,526	325,234	8.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,192	2,374	24,624	10.37	9
10	Activity Assistants	1,819	2,135	14,303	6.70	10
11	Social Service Workers	1,796	1,986	22,622	11.39	11
12	Dietician					12
13	Food Service Supervisor	1,833	2,135	22,566	10.57	13
14	Head Cook	5,670	6,483	44,997	6.94	14
15	Cook Helpers/Assistants	4,822	5,661	45,122	7.97	15
16	Dishwashers					16
17	Maintenance Workers	1,860	2,147	23,048	10.73	17
18	Housekeepers	6,550	7,214	47,347	6.56	18
19	Laundry	3,365	3,860	25,416	6.58	19
20	Administrator	1,839	2,093	55,111	26.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,603	2,963	32,119	10.84	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS, CHAPLAIN	1,697	1,975	34,492	17.46	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	82,715	92,476	$ 1,006,027 *	$ 10.88	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fees	$ 4,094	1-3	35
36	Medical Director	monthly fees	4,200	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fees	600	10-3	39
40	Physical Therapy Consultant	monthly fees	2,538	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	monthly fees	1,850	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,282		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHRISTINE HAMILTON	ADMIN		$ 55,111
	ASST ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,111

B. Administrative - Other

Description	Amount
HI CARE MANAGEMENT INC	$ 13,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 13,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ACHIEVE SOFTWARE	DATA PROCESSING	$ 5,158
HEALTH CARE HORIZONS	DATA PROCESSING	6,500
NIHAN AND MARTIN	DATA PROCESSING	2,460
IVANS	DATA PROCESSING	682
KRUPNICK BOKOER	ACCOUNTING	17,550
RICHARD PEELO	MEDICARE CONSULT	3,000
DUANE MORRIS	LEGAL	8,620
PERSONNEL PLANNER	U/C CONSULTANT	752
RRCA ACCOUNTS MGMT		386
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 45,108

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 47,650
Unemployment Compensation Insurance		52,470
FICA Taxes		77,268
Employee Health Insurance		11,894
Employee Meals		3,194
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		7,374
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 199,850

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,877
Health Care Worker Background Check	1,152
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	4,071
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	441
DUES & SUBSCRIPTIONS	323
MGMT CO ALLOCATION	398
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,282)
Yellow page advertising	(1,789)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,181

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	1,184
Seminar Expense	
	194
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,378

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING	07/99	$ 4,771	3 YR	$ 796	$	$	$	$	$	$	$	$
2	PAINT/DECORATING	07/00	3,379	3 YR	1,126	564							
3	PAINT/DECORATING	07/04	1,889	3 YR			315	630	630	314			
4	PAINT/DECORATING	07/05	1,943	3 YR				325	647	647	324		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 11,982		$ 1,922	$ 564	$ 315	$ 955	$ 1,277	$ 961	$ 324	$	$

Facility Name & ID Number NEW BEGINNINGS CARE CENTRE # 0035642 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,002** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **30,447**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,194** Has any meal income been offset against related costs? **YES** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees